CALIFORNIA CASE REPORT FORM FOR SUSPECT AVIAN (H5N1) INFLUENZA

NOTE: If case also meets epidemiologic and clinical criteria for severe acute respiratory syndrome (SARS), please fill out the "California Case Report Form for SARS-like Illness" and the **grey-colored sections 2, 3, 5, 6, 7 and 9** of this form. For fatal cases, please attach copy of autopsy report, if available. Please refer to the WHO website at **http://www.who.int/csr/disease/avian_influenza/en/** for an updated list of affected countries.

FAX completed form to 510-307-8599

Date of Initial report to LHD: _____/_____/_____ **State ID#**_____

Section 1. Patient Information

Patient's Last Name: _____ **First Name:** _____ **MI:** _____

Current Street Address: _____

Current Residence City: _____ **State:** _____ **County:** _____

Home telephone: _____ **Work telephone:** _____

Age at onset: _____ ☐ Years ☐ Months **Date of Birth** ___/___/___ **Gender:** ☐ Male ☐ Female

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

Race: ☐ Native American/Alaskan Native ☐ Asian ☐ Pacific Islander ☐ African American/Black ☐ White ☐Other ☐Unk

Nationality/Citizenship: _____ **Residency:** ☐ U.S. Resident ☐ Non-U.S. Resident

Specify patient occupation: _____

Is individual a health care worker (a person who has close contact to patients, patient care areas (e.g., patient's room) or patient care items (e.g., linens or clinical specimens)? ☐ Yes ☐ No ☐ Unk

If yes, specify:

Health care worker type: ☐ Physician ☐ Nurse/ PA ☐ Laboratorian ☐ Other _____

Place of employment: ☐ Hospital ☐ Long Term Care Facility ☐ Laboratory ☐ Ambulatory Care ☐ Other_____

Does patient have DIRECT patient care responsibilities?)? ☐ Yes ☐ No ☐ Unk

Section 2. Risk Factors for Influenza Complications

☐ Cardiac disease _____

☐ Chronic lung disease (e.g, asthma) _____

☐ Chronic metabolic/renal disease (e.g., diabetes) _____

☐ Immunosuppression (e.g., HIV, transplant, malignancy, long-term steroids)_____

☐ Child < 18 yrs old on chronic aspirin therapy _____ ☐ Hemoglobinopathy (e.g., SCD) _____

☐ Pregnancy in 2nd or 3rd trimester _____ ☐ Nursing home resident / institutionalized _____

☐ Other underlying illness (specify): _____

Section 3. Signs and Symptoms

Date of initial symptom onset: _____/_____/_____

Fever (subjective or objective): ☐ Yes ☐ No ☐ Unk *If yes,* **date of fever onset:** _____/_____/_____

If yes, **temperature >38º C (>100.4º F):** ☐ Yes ☐ No ☐ Unk

Influenza-associated symptoms: ☐ Chills ☐ Rigors ☐ Myalgias ☐ Headache ☐ Sore throat ☐ Runny nose/congestion

☐ Conjunctivitis ☐ Cough ☐ Wheezing ☐ Shortness of breath ☐ Bloody respiratory secretions ☐ Ear pain/otitis

☐ Nausea/vomiting ☐ Diarrhea ☐ Abdominal pain ☐ Apnea ☐ Lethargy ☐ Altered mental status ☐ Other: _____

Complications: ☐ Encephalitis ☐ Myocarditis ☐ Seizures ☐ Sepsis ☐ Multi-organ failure

☐ Reyes Syndrome ☐ 2º bacterial pneumonia ☐ Other_____

Antiviral medications: ☐ Yes ☐ No ☐ Unk

If yes, **specify:** ☐ Amantadine ☐ Rimantadine ☐ Oseltamivir ☐ Zanamavir **Date started**: ____ /_____/_____

Received flu vaccine for 2003-2004 season: ☐ Yes ☐ No ☐ Unk *If yes*, **specify date:** ____/_____/_____

Comments:

CDC ID#: _____ CDHS ID#: _____

Section 4. Clinical Status

Date of first clinical evaluation for this illness: ____ /____/____

Laboratory results (if available): **Platelet count** _____ **Liver function: AST:**_____ **ALT:** _____

White blood cell count: _____ **differential:** _____**segs** _____**lymphs**_____**monos**_____**baso**_____**atyp lymph**

Was a chest X-ray or chest CAT scan performed? ☐ Yes ☐ No ☐ Unk If yes, **date:** _____ /_____/_____
If yes, **was there evidence of pneumonia or respiratory distress syndrome?** ☐ Yes ☐ No ☐ Unk
Comments/interpretation: _____

Was the patient hospitalized for > 24 hours during this course? ☐ Yes ☐ No ☐ Unk
If yes: **Name of hospital:** _____ **Medical Record Number**:_____
City: _____ **State:** _____
Date of admission: _____/_____/_____ **Date of discharge:** _____/_____/_____

Was the patient transferred to or from another facility? ☐ Yes ☐ No ☐ Unk
If yes, **facility name:** _____
If yes, **date of transfer:** _____/_____/_____ *(If more, please list on back of page).*

Was the patient ever in the ICU? ☐ Yes ☐ No ☐ Unk

Was the patient ever placed on mechanical ventilation? ☐ Yes ☐ No ☐ Unk

Did the patient die as a result of this illness? ☐ Yes ☐ No ☐ Unk
If yes, **date of death:** _____/_____/_____
If yes, **was an autopsy performed?** ☐ Yes ☐ No ☐ Unk *If yes,* **please forward autopsy report.**

Section 5. Avian (H5N1) Influenza Epidemiological Risk Factors

In the 10 days prior to symptom onset:

Did the patient travel to an area with documented avian (H5N1) influenza in birds and/or humans? ☐ Yes ☐ No ☐ Unk

If yes, **1. Complete section 6.**

2. Did the patient have history of contact with domestic poultry? ☐ Yes ☐ No ☐ Unk

If yes, **a. Did the patient come within one meter of any poultry?** ☐ Yes ☐ No ☐ Unk
b. Was the poultry sick or dying? ☐ Yes ☐ No ☐ Unk
c. Did the patient touch any live poultry? ☐ Yes ☐ No ☐ Unk
d. Did the patient touch any recently butchered poultry? ☐ Yes ☐ No ☐ Unk

Did the patient come in close contact or stay in the same household with a known or suspected human case of H5N1?

☐ Yes ☐ No ☐ Unk (If YES to exposure to ill traveler, please fill out source case information in SECTION 9)

Did the patient come in close contact or stay in the same household with anyone with pneumonia or severe flu-like illness?

☐ Yes ☐ No ☐ Unk

Section 6. Travel History

Complete if travel to foreign or domestic area with documented or suspected recent local transmission of **avian (H5N1) influenza** cases in birds or humans. **List each portion or leg of the trip in the space below.** Copy or use additional pages if necessary.

Leg 1
Departure Date: ____/____/____ **Departure City/Country:** _____
Arrival Date: ____/____/____ **Arrival City/Country**: _____

Leg 2
Departure Date: ____/____/____ **Departure City/Country:** _____
Arrival Date: ____/____/____ **Arrival City/Country:** _____

Leg 3
Departure Date: ____/____/____ **Departure City/Country:** _____
Arrival Date: ____/____/____ **Arrival City/Country:** _____

Please complete Annex 1 to provide more detailed travel history

CDC ID#: _____ CDHS ID#: _____

Section 7. Local Hospital/Outpatient/Public Health Laboratory Results

Date of first specimen collection: _____/_____/_____

Blood culture: ☐ Not done ☐ Neg ☐ Pos ☐ Unk Organism isolated: _____ Collection Date: _____/_____/_____

Respiratory culture: ☐ Not done ☐ Neg ☐ Pos ☐ Unk Organism isolated: _____Collection Date: _____/_____/_____

If done, **specimen type:** ☐ nasopharyngeal swab ☐ nasopharyngeal wash ☐ oropharyngeal swab ☐ endotracheal asp ☐ sputum ☐ bronchoalveolar lavage ☐ pleural fluid

Rapid influenza test: ☐ Not done ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

If done, **specimen type:** ☐ nasopharyngeal swab ☐ nasopharyngeal wash ☐ oropharyngeal swab ☐ endotracheal asp ☐ sputum ☐ bronchoalveolar lavage ☐ pleural fluid

Rapid RSV test: ☐ Not done ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

If done, **specimen type:** ☐ nasopharyngeal swab ☐ nasopharyngeal wash ☐ oropharyngeal swab ☐ endotracheal asp ☐ sputum ☐ bronchoalveolar lavage ☐ pleural fluid

Other hospital/outpatient tests: Test: _____ Result: _____ Collection date: _____/_____/_____
Test: _____ Result: _____Collection date: _____/_____/_____

Local public health lab results (if available):

If done, **specimen type:** ☐ nasopharyngeal swab ☐ nasopharyngeal wash ☐ oropharyngeal swab ☐ endotracheal asp ☐ sputum ☐ bronchoalveolar lavage ☐ pleural fluid

Results:_____

_____

Section 8. Alternative Diagnosis

Was an alternative respiratory pathogen detected for the patient? ☐ Yes ☐ No ☐ Unk

If yes, **indicate which pathogen(s):** _____

(e.g., influenza A/B, RSV, rhinovirus, adenovirus, human parainfluenza virus, human metapneumovirus, *Streptococcus pneumoniae, Haemophilus influenzae, Mycoplasma pneumoniae*, *Chlamydia pneumoniae, Legionella sp.*)

Section 9. Source Case and Contact Information

Please complete **Annex 2** to provide source case information for a patient with *any* history of contact with a known or suspected human case of **influenza A (H5N1)** within 10 days of symptom onset.

In contrast to source case information, contact information in this section refers to those individuals the patient has had contact with **since** becoming ill. Unless otherwise specified, CDHS will not routinely request the information you collect on "trace-forward" contacts, but you may want to maintain a list in case of laboratory confirmation for H5N1. If you would like to consult with a member of the avian influenza team at CDHS, please call Janice Louie or Carol Glaser (510) 307-8585, Duc Vugia (510) 620-3434, Howard Backer or Trevor Shoemaker (510) 620-3737.

Section 10. Submitted by

Last Name: _____ First Name: _____ Phone: (____)_____

Affiliation: _____ County: _____Fax:_____ E-mail: _____

Section 11. Additional Comments

CDC ID#: _____ CDHS ID#: _____

Annex 1. Supplemental Travel History

Complete if provided a more detailed travel history to foreign or domestic areas with documented or suspected recent local transmission of **avian (H5N1) influenza** cases in birds or humans. Copy or use additional pages if necessary.

Leg 1
Transport type: ☐ Airline ☐ Train ☐ Auto ☐ Cruise ☐ Bus ☐ Tour group ☐ Other _____
Transport company: _____ **Transport number:** _____
Residence at arrival city (e.g., hotel, relative's home):_____ **Purpose/activities:**_____

Leg 2
Transport type: ☐ Airline ☐ Train ☐ Auto ☐ Cruise ☐ Bus ☐ Tour group ☐ Other _____
Transport company: _____ **Transport number:** _____
Residence at arrival city (e.g, hotel, relative's home): _____**Purpose/activities:**_____

Leg 3
Transport type: ☐ Airline ☐ Train ☐ Auto ☐ Cruise ☐ Bus ☐ Tour group ☐ Other _____
Transport company: _____ **Transport number:** _____
Residence at arrival city (e.g., hotel, relative's home): _____ **Purpose/activities:**_____

Annex 2. Source Case Information

This section should be filled out If the patient reported *any* history of contact with a known or suspected human case of **influenza A (H5N1)** within 10 days of symptom onset. Please be sure to submit a case report form for the source case as well. If the source case is not a resident of your county or not a California resident, please collect as much information as possible about the source case and contact a member of the state avian (H5N1) influenza team so they may contact appropriate individuals for follow-up.

If the patient lists more than two possible source cases, please use additional pages or space below.

Source Case 1:
Name: _____ **Age**:_____ ☐ Years ☐ Months **Gender:** ☐ Male ☐ Female
Address: _____
City: _____ **County:** _____ **State:** _____
Telephone (h): (____)_____ **Telephone (w):** (____)_____
Nature of contact: ☐ Household ☐ Co-worker ☐ Health care ☐ Other
Please describe the nature of the contact:
Date of patient's last exposure to source case: _____/_____/_____
Has a case report form been completed on source case? ☐ Yes ☐ No ☐ Unk ☐ In Progress
If yes, **date of completion:** _____/_____/_____
If known, **source case's CDC ID#:** _____ **CDHS#:** _____ **Local ID #:** _____
Did the ill contact recently travel to a country with documented H5 infected poultry or human cases? ? ☐ Yes ☐ No ☐ Unk
If yes, list countries: _____

Source Case 2:
Name: _____ **Age**:_____ ☐ Years ☐ Months **Gender:** ☐ Male ☐ Female
Address: _____
City: _____ **County:** _____ **State:** _____
Telephone (h): (____)_____ **Telephone (w):** (____)_____
Nature of contact: ☐ Household ☐ Co-worker ☐ Health care ☐ Other
Please describe the nature of the contact:
Date of patient's last exposure to source case: _____/_____/_____
Has a case report form been completed on source case? ☐ Yes ☐ No ☐ Unk ☐ In Progress
If yes, **date of completion:** _____/_____/_____
If known, **source case's CDC ID#:** _____ **CDHS#:** _____ **Local ID #:** _____
Did the ill contact recently travel to a country with documented H5 infected poultry or human cases? ? ☐ Yes ☐ No ☐ Unk
If yes, list countries: _____

CDC ID#: _____ CDHS ID#: _____

Annex 3. (To be filled out by DHS personnel)

VRDL Results (if available):
Date of specimen: ____/_____/____
Specimen type: ☐ nasopharyngeal swab ☐ nasopharyngeal wash ☐ oropharyngeal swab ☐ endotracheal asp
☐ sputum ☐ bronchoalveolar lavage ☐ pleural fluid
Results:_____

CDC Results (if available):
Date of specimen: ____/_____/____
Specimen type: ☐ nasopharyngeal swab ☐ nasopharyngeal wash ☐ oropharyngeal swab ☐ endotracheal asp
☐ sputum ☐ bronchoalveolar lavage ☐ pleural fluid
Results:_____

CDC Contact (if further laboratory testing required):
Last Name: _____ First Name: _____ Phone: (____)_____
E-mail: _____ Date reported to CDC: ___/____/_____ CDC ID#: _____

Case Classification:

☐ Case under investigation ☐ Epidemiologic/clinical investigation completed, lab results pending

☐ Suspect H5 case (investigation completed, no lab results available) ☐ Influenza A (human subtype H1, H3)

☐ Ruled out case ☐ Other etiology (list) _____ ☐ H5 case (laboratory confirmed)